BlueChoice Advantage HSA/HRA $1,500

Summary of Benefits

Services	In-Network You Pay[1]	Out-of-Network You Pay[2]
ANNUAL DEDUCTIBLE (BENEFIT PERIOD)[3]		
Individual	$1,500	$3,000
Family	$3,000	$6,000
ANNUAL OUT-OF-POCKET MAXIMUM (BENEFIT PERIOD)[4]		
Individual	$4,000	$6,000
Family	$8,000	$12,000
LIFETIME MAXIMUM BENEFIT		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	40% of Allowed Benefit
Adult Physical Examination	No charge*	40% of Allowed Benefit
Routine GYN Visits	No charge*	40% of Allowed Benefit
Breast Cancer Screening	No charge*	40% of Allowed Benefit
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge*	40% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING		
Facility fee for services rendered in a hospital setting)[5]	Deductible, then $50 per visit	Deductible, then 40% of Allowed Benefit
Office Visits for Illness[5]	Deductible, then $20 PCP/$30 Specialist	Deductible, then 40% of Allowed Benefit
Diagnostic Services/Lab Tests (LabCorp only)[5]	Deductible, then $30 per visit	Deductible, then 40% of Allowed Benefit
X-ray (Freestanding Facility only)	Deductible, then $30 per visit	Deductible, then 40% of Allowed Benefit
Allergy Testing & Shots[5]	Deductible, then $30 per visit	Deductible, then 40% of Allowed Benefit
Outpatient Physical, Speech and Occupational Therapy[5] (limited to 30 visits/illness or injury/benefit period)	Deductible, then $40 per visit	Deductible, then 40% of Allowed Benefit
Outpatient Chiropractic[5] (limited to 20 visits/condition/benefit period)	Deductible, then $40 per visit	Deductible, then 40% of Allowed Benefit
EMERGENCY CARE AND URGENT CARE		
Urgent Care Center	Deductible, then $40 per visit	Paid as in-network
Hospital Emergency Room	Deductible, then $100 per visit (waived if admitted)	Paid as in-network
Emergency Room–Professional Services	No charge* after deductible	Paid as in-network
Ambulance (if medically necessary)	No charge* after deductible	No charge* after deductible
HOSPITALIZATION		
Outpatient Facility Non-Surgery (Hospital Facility)[5]	Deductible, then $50 per visit	Deductible, then 40% of Allowed Benefit
Outpatient Facility Surgery (Freestanding Facility)	Deductible, then $100 per visit	Deductible, then 40% of Allowed Benefit
Outpatient Facility Surgery (Hospital Facility)	Deductible, then $250 per visit	Deductible, then 40% of Allowed Benefit
Outpatient Physician Services	Deductible, then $30 per visit	Deductible, then 40% of Allowed Benefit
Inpatient Facility Services	Deductible, then $250 per admission	Deductible, then 40% of Allowed Benefit
Inpatient Physician Services	No charge* after deductible	Deductible, then 40% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care	No charge*	Deductible, then 40% of Allowed Benefit
Hospice	No charge*	Deductible, then 40% of Allowed Benefit
Skilled Nursing Facility (limited to 100 days/benefit period)	Deductible, then $40 per admission	Deductible, then 40% of Allowed Benefit

Note: Plan has an integrated medical and prescription drug deductible.

Services	In-Network You Pay[1]	Out-of-Network You Pay[2]
MATERNITY		
Prenatal and Postnatal Office Visits[5]	No charge*	Deductible, then 40% of Allowed Benefit
Delivery and Facility Services	Deductible, then $250 per admission	Deductible, then 40% of Allowed Benefit
Nursery Care of Newborn	No charge* after deductible	Deductible, then 40% of Allowed Benefit
Artificial Insemination[6] (limited to 6 attempts/live birth	Deductible, then $40 per visit	Deductible, then 40% of Allowed Benefit
In Vitro Fertilization Procedures[6]	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Facility Services	Deductible, then $250 per admission	Deductible, then 40% of Allowed Benefit
Inpatient Physician Services	Deductible, then $30 per visit	Deductible, then 40% of Allowed Benefit
Outpatient Facility Services	Deductible, then $30 per visit	Deductible, then 40% of Allowed Benefit
Outpatient Physician Services	Deductible, then $30 per visit	Deductible, then 40% of Allowed Benefit
Office Visits[5]	Deductible, then $20 per visit	Deductible, then 40% of Allowed Benefit
Partial Hospitalization Facility Services	Deductible, then $30 per visit	Deductible, then 40% of Allowed Benefit
Partial Hospitalization Physician Services	Deductible, then $30 per visit	Deductible, then 40% of Allowed Benefit
Medication Management[5]	Deductible, then $20 per visit	Deductible, then 40% of Allowed Benefit
MISCELLANEOUS		
Durable Medical Equipment	No charge* after deductible	Deductible, then 40% of Allowed Benefit
Acupuncture[5]	Deductible, then $40 per visit	Deductible, then 40% of Allowed Benefit
Hearing Aids (limited to minor children and limited to one hearing aid per hearing-impaired ear every 36 months)	No charge* after deductible	Deductible, then 40% of Allowed Benefit
PRESCRIPTION DRUGS		
Preferred Preventive Drugs	No charge*	
Generic Drugs	34-day supply-Deductible, then $10; 90-day supply-Deductible, then $20	
Preferred Brand Name Drugs	34-day supply-Deductible, then $45; 90-day supply-Deductible, then $90	
Non-Preferred Brand Name Drugs	34-day supply-Deductible, then $65; 90-day supply-Deductible, then $130	
Specialty Drugs	Deductible, then 50% coinsurance	
PEDIATRIC VISION (UNDER 19)		
Routine Exam (limited to 1 visit/benefit period)	No charge*	Total charge minus $40 reimbursement
Frames and Contact Lenses–Pediatric Collection Only	No charge*	Reimbursements apply
Spectacle Lenses	$150 allowance for non-collection frames/contact lenses	Reimbursements apply
PEDIATRIC DENTAL (UNDER 19)		
Dental Deductible	$25	$50
Class I Preventive & Diagnostic Services	No charge*	20% of Allowed Benefit
Class II Basic Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Class III Major Services–Surgical	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Class IV Major Services–Restorative	Deductible, then 50% of Allowed Benefit	Deductible, then 65% of Allowed Benefit
Class V Medically-Necessary Orthodontic Services	50% of Allowed Benefit	65% of Allowed Benefit

* No copayments or coinsurance.

[1] In-Network: When covered services are rendered in Maryland, Washington D.C. and/or Northern Virginia, collectively known as the CareFirst BlueChoice service area, by a provider in the CareFirst BlueChoice Provider network, care is reimbursed at the in-network level. In-network benefits are based on the CareFirst BlueChoice Allowed Benefit. The CareFirst BlueChoice Allowed Benefit is generally the contracted rates or fee schedules that CareFirst BlueChoice providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueChoice, Inc., however, in certain circumstances, an allowance may be established by law. Outside of the CareFirst BlueChoice service area, when covered services are rendered by a provider in the preferred provider network, care is also covered at the in-network level. These in-network benefits are based on the contracted rates or fee schedules that preferred providers have agreed to accept as payment for covered services that are established by the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.

[2] Out-of-Network: When covered services are rendered by a provider that is not in the CareFirst BlueChoice network in Maryland, Washington D.C. or Northern Virginia, or is not in the preferred provider network outside of CareFirst BlueChoice service area, the care is reimbursed as out-of-network. Out-of-network benefits are based on the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that are established by CareFirst BlueChoice, or the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.

[3] The deductible can be met entirely by one Member or by combining eligible expenses of two or more members. There is no Individual Deductible with Family Coverage. The Family Deductible must be reached before CareFirst BlueChoice pays benefits for any Member who has other than Individual Coverage. Please refer to your Evidence of Coverage to determine your coverage level.

[4] The Out-of-Pocket Maximum can be met entirely by one Member or by combining eligible expenses of two or more members. There is no Individual Out-of-Pocket Maximum with Family Coverage. The Family Out-of-Pocket Maximum must be reached before CareFirst BlueChoice pays benefits for any Member who has other than Individual Coverage. Please refer to your Evidence of Coverage to determine your coverage level.

[5] An additional facility copay may apply to services rendered in a hospital setting.

[6] Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. However, assisted reproduction (AI, IVF & Intrauterine Insemination) services performed as treatment options for infertility are only available under the terms of the members contract.

Not all services and procedures are covered by your benefits contract. This summary is for comparison purposes only and does not create rights not given through the benefit plan.

The benefits described are issued under form numbers: MD/CFBC/GC (1/14) • MD/CFBC/ADV IN/EOC (1/14) • MD/CFBC/DOL APPEAL (R. 9/11) • MD/CFBC/SHOP/ADV IN/DOCS (1/14) • MD/CFBC/BC ADV IN/1500 CDH SOB (1/14) • MD/CFBC/ELIG (1/14) • MD/CF/GC (1/14) • MD/CF/ADV OON/EOC (1/14) • MD/GHMSI/DOL APPEAL (R. 9/11) • MD/CF/SHOP/ADV OON/DOCS (1/14) • MD/CF/BCADV OON/1500 CDH SOB (1/14) • MD/CF/ELIG (1/14) • CFMI/GC (1/14) • CFMI/ADV OON/

CareFirst BlueChoice

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